AMENDED IN ASSEMBLY JULY 15, 2003

AMENDED IN ASSEMBLY JULY 2, 2003

AMENDED IN SENATE APRIL 22, 2003

SENATE BILL No. 853

Introduced by Senator Escutia
(Coauthor: Senator Perata)

February 21, 2003

An act to amend Section 1367 of, and to add Section 1367.04 to, the Health and Safety Code, and to add Section 10133.4 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 853, as amended, Escutia. Health care service plans: culturally and linguistically appropriate services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

This bill would require the department to adopt, not later than January 1, 2006, regulations ensuring access to language assistance and culturally competent health care services. Pursuant to the bill, the regulations would require health care service plans and specialized health care service plans to implement programs to assess subscriber needs, and to provide translation, interpretation, and culturally competent medical services, and would require that the regulations include a process to determine if a health care service plan is required to meet the same or similar standards imposed by a

government-sponsored program and whether compliance with those standards meets or exceeds the standards established by the department in its regulations. The bill would require the department to consider specified factors and to seek public input. The department would be required to regularly review information regarding compliance and make recommendations for changes and to report certain information annually to the Legislature and specified advisory committees. This bill would impose similar requirements on the Insurance Commissioner with respect to health insurers that contract with providers for alternative rates of payment to ensure that insureds have access to translated materials, language assistance, and culturally competent health care services, as appropriate.

This bill would require a contract between a health care service plan and a health care service provider to ensure compliance with the standards adopted by the board~~,~~.

By placing additional requirements on health care service plans, the violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the

location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director’s enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

SEC. 2. Section 1367.04 is added to the Health and Safety Code, to read:

1367.04. (a) Not later than January 1, 2006, the department shall develop and adopt regulations to ensure that enrollees have access to language assistance and culturally competent health care services, as appropriate.

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the needs of the subscriber population and to provide for translation, interpretation, and culturally competent medical services, as indicated. The regulations shall include the following:

(1) Requirements for determining whether written materials shall be translated, such as establishing population threshold triggers based on the enrollee population. The documents required to be translated shall include the following:

(A) All documents produced by the plan *for distribution to enrollees.*

(B) ~~All documents distributed by the plan.~~

~~(C)~~ All documents that the plan requires by contract *that are distributed to enrollees.*

(2) Standards to ensure the quality and accuracy of written translations, including to ensure the appropriate literacy level for the enrollee population.

(3) Requirements for individual enrollee access to interpretation services.

(4) Standards to ensure the quality and timeliness of oral interpretation services provided by plans.

(5) An operational definition of cultural competency that meets all of the following criteria:

(A) That recognizes the diversity among enrollees.

(B) That seeks to address, understand, and remove cultural and linguistic barriers.

(C) That is consistent with appropriate medical practice.

(6) Standards to evaluate the progress of plans in meeting the definition of cultural competency.

(c) In developing the regulations, standards, and requirements, the department shall consider the following:

(1) Publications and standards issued by federal agencies, such as the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health

and Human Services Office of Minority Health in December 2000, and the Department of Health and Human Services (FIHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, such as Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health care service plans that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists established by Section 852 of the Business and Professions Code.

(6) Examples of best practices by providers and health plans, including existing practices.

(7) Information gathered from complaints to the HMO Helpline and consumer assistance centers.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in plan networks and method of service delivery.

(d) The department shall seek public input from a wide range of interested parties through the Advisory Committee on Managed Health Care or other advisory bodies established by the director.

(e) ~~(1)~~ A contract between a health care service plan and a health care provider shall require compliance with the standards developed under this section. In furtherance of this section, the contract shall require providers to cooperate with the plan by providing any information necessary to assess compliance.

~~(2) Services, verbal communications, and written materials provided by or developed by the plan shall comply with standards developed under this section.~~

~~(3)~~

(f) The department shall report annually to the Legislature and the Advisory Committee on Managed Health Care, or other advisory bodies established by the director, regarding plan compliance with the standards, including results of compliance audits. The reported information shall also be included in the publication required under subparagraph (B) of paragraph (3) of subdivision (c) of Section 1368.02.

~~(f)~~

(g) The department shall regularly review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. The department may also delay or otherwise phase in implementation of standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

~~(g)~~

(h) (1) The standards developed under this section shall be considered the minimum required for compliance.

(2) The regulations shall provide that a health plan is in compliance if the plan is required to meet the same or similar standards by a government sponsored program such as Medi-Cal or Healthy Families, either by contract or state law, if the standards provide as much access to cultural and linguistic services as the standards established by this section for an equal or higher number of enrollees and therefore meet or exceed the standards of the regulations established pursuant to this section, and the department determines that the health care service plan is in compliance with the standards required by the government sponsored program. To meet this requirement, the department shall not be required to perform individual audits. The department shall, to the extent feasible, rely on audits, reports or other oversight and enforcement methods used by State Department of Health Services or the Managed Risk Medical Insurance Board.

(3) The determination pursuant to paragraph (2) shall only apply to the enrollees covered by the government sponsored program standards. A health care service plan subject to paragraph

(2) shall comply with the standards established by this section with regard to enrollees not covered by the government sponsored program.

SEC. 3. Section 10133.4 is added to the Insurance Code, to read:

10133.4. (a) The commissioner shall, on or before January 1, 2006, promulgate regulations applicable to health insurers that contract with providers for alternative rates pursuant to Section 10133, in order to ensure that insureds have access to translated materials, language assistance, and culturally competent health care services, as appropriate.

(b) These regulations shall be designed to ensure that translated materials, language assistance, and culturally competent health care services are accessible, as appropriate, to individuals comprising the insured group, pursuant to benefits covered under the policy or contract. The regulations shall include the following:

(1) A requirement to conduct an assessment of the needs of the insured group.

(2) Requirements for determining whether written materials shall be translated, such as establishing threshold triggers based on the enrollee population. The documents required to be translated shall include all of the following:

(A) Documents produced by the health insurer *that are distributed to enrollees*.

(B) ~~Documents distributed by the health insurer.~~

~~(C)~~ Documents required by contract with providers.

(3) Standards to ensure the quality and accuracy of written translations, including to ensure the appropriate literacy level for the subscriber population.

(4) Requirements for individual access to interpretation services.

(5) Standards to ensure the quality and timeliness of oral interpretation services provided by health insurers.

(6) An operational definition of cultural competency that meets all of the following criteria:

(A) That recognizes the diversity among subscribers.

(B) That seeks to address, understand, and remove cultural and linguistic barriers.

(C) That is consistent with appropriate medical practice.

(7) Standards to evaluate the progress of health insurers in meeting the definition of cultural competency.

(c) In developing the regulations, standards, and requirements, the commissioner shall consider the following:

(1) Publications and standards issued by federal agencies, such as the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the Department of Health and Human Services (FIHS) Office of Civil Rights (OCR) Policy Guidance 65 Federal Register 52762 (August 30, 2000).

(2) Other cultural and linguistic requirements under state programs, such as Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health care service plans that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists required pursuant to Section 852 of the Business and Professions Code.

(6) Examples of best practices by providers and health insurers that contract for alternative rates of payment with providers, including existing practices.

(7) Information gathered from complaints to the commissioner and consumer assistance help lines.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in networks and method of service delivery.

(d) In designing the regulations, the commissioner shall consider the provisions of Title 28 (commencing with Section 1300.67.2) of the California Code of Regulations that are applicable to health care service plans, and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost-efficient system of indemnification. The commissioner shall consult with the Department of Managed Health Care concerning regulations developed by that department pursuant to Section 1367.04 of the Health and Safety Code and shall seek public input from a wide range of interested parties.

~~(e) Services, verbal communications, and written materials provided by or developed by the health insurers that contract for alternative rates of payment with providers shall comply with the standards developed under this section.~~

~~(f)~~

(e) (1) Health insurers that contract for alternative rates of payment with providers of health care shall report annually to the commissioner regarding compliance with the standards, in a manner specified by the commissioner.

(2) The information reported pursuant to paragraph (1) shall be made available to the public and shall allow a consumer to compare the performance of health insurers that contract for alternative rates of payment with providers against the performance of his or her health insurer in complying with the standards.

~~(g)~~

(f) The commissioner shall regularly review information regarding compliance with the standards developed under this section, and shall make recommendations for changes that further protect insureds. The commissioner may also delay or otherwise phase in implementation of the standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

~~(h)~~

(g) Health insurers that contract for alternative rates of payment with providers shall report annually on complaints received by the insurer regarding access to linguistically and culturally competent care. The commissioner shall review these complaints and any complaints received by the commission and shall make public this information.

~~(i)~~

(h) Every three years, the commissioner shall review the latest version of the regulations adopted pursuant to subdivision (a) and shall determine if the regulations should be updated to further the intent of this section.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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